FAMILY PLANNING SERVICES

1. **Purpose**: To ensure that family planning services are available to all sexually active residents; and to provide education, counseling and training in preventive measures regarding sexually transmitted diseases, including HIV infection, to all appropriate Florida State Hospital residents.

2. **Scope**: This procedure applies to all Florida State Hospital residential units.

3. **Training Requirements**: All physicians, Advanced Registered Nurse Practitioners, and nurses will be trained on this operating procedure upon hire into the position during Discipline-Specific Education and by their supervisor each time the operating procedure is revised.

4. **Reference**:
   
   
   
   c. Florida State Hospital Operating Procedure 153-33, Sexually Transmitted Disease Control Program.

5. **Procedure**:
   
   a. Education and Counseling:

   (1) Educational programs on human sexuality, family planning, prevention of pregnancy, sexually transmitted diseases, including HIV infection and preventive measures, shall be provided to all Florida State Hospital residents by the Unit Nursing Staff/Unit Recovery Team.

   (2) Provision of these educational programs shall be documented on the Immunization/Treatment Record Communicable Diseases/Education Form (see Attachment 1) by the unit nursing staff.

   (3) If the resident refuses to receive these educational services, the refusal shall be documented on the Temporary Medical/Other Service Needs form. It will be the responsibility of the designee to encourage the resident to participate in the education program.
b. Family Planning Services and Preventive Measures for Sexually Transmitted Diseases:

(1) It shall be the responsibility of each Unit Recovery Team to designate someone to offer family planning services and preventive measures for sexually transmitted diseases (see Attachment 2) to all sexually active residents.

(2) Upon satisfactory completion of Family Planning/Sexually Transmitted Diseases Education by the Recovery Team or designee, each resident may, upon request, be provided appropriate preventive measures, including condoms and/or other prophylactic devices, following his/her request. The Physician, Advanced Registered Nurse Practitioner, Physician's Assistant, or Nursing Staff will familiarize the resident with the proper use of the prophylactic device.

(3) The individual resident who requests family planning services shall be referred to the GYN Clinic by the ward Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant.

(4) The ward Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant in the resident's home unit shall perform a preliminary work-up prior to the scheduled GYN Clinic appointment. The following is to be included and on the resident's ward chart when seen in GYN Clinic:

(a) comprehensive medical history form (especially if resident has prior pelvic inflammatory disease) (see Attachment 3) shall be completed;

(b) SMA-15;
(c) RPR;
(d) CBC;
(e) U/A;
(f) Gonorrhea Culture;
(g) Chlamydia Culture;
(h) Serum Pregnancy Test;
(i) Pap Smear.

(5) Individual education and counseling regarding the various methods of birth control, side effects, benefits and risks shall be provided to the resident by the ward Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant as part of the preliminary work-up.

(6) Specific individual evaluation and counseling in order to determine the most appropriate method of birth control shall be provided by the physician at the time of the resident's GYN Clinic appointment.
(7) The proper consent form for the designated family planning device or medication shall be completed and signed in the GYN Clinic. The resident's Recovery Team will assume responsibility for any additional consent forms from First Representatives, Guardian Advocates or Courts (see Attachments 4 and 5).

c. Monitoring:

(1) The ward Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant shall provide additional counseling and evaluation of prescribed family planning method in use by the resident at the end of six (6) months.

(2) The resident shall be seen in the GYN Clinic annually for follow-up care.

(3) At the time for the annual physical exam, the ward Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant shall request that the Pap Smear be checked for the presence of Actinomyces if the resident has an IUD in place.

d. Refusal of Family Planning Services: If a resident refuses family planning services, documentation should be made on the Temporary Medical/Other Service Needs form. The family planning services should be offered every 90 days to resident by the Recovery Team.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES
Hospital Administrator

<table>
<thead>
<tr>
<th>Attachments</th>
<th>5 Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Immunization/Treatment Record</td>
</tr>
<tr>
<td></td>
<td>Communicable Diseases/Education Form (Form 13)</td>
</tr>
<tr>
<td>2.</td>
<td>Family Planning Services Questionnaire (Form 578)</td>
</tr>
<tr>
<td>3.</td>
<td>Adult Health History/Family Planning Services (Form 586)</td>
</tr>
<tr>
<td>4.</td>
<td>(Combined) Oral Contraceptive Consent Form (Form 587) and Instructions For Taking Your Birth Control Pills</td>
</tr>
<tr>
<td>5.</td>
<td>Intrauterine Device (IUD) Consent Form (Form 584) and Instructions For Your IUD</td>
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</tbody>
</table>

---

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Paragraph 5b(1) was revised by deleting “Also the Unit Recovery Team may involve educational services or make a referral to the Health Department.”

The procedure regarding the refusal of family planning services (paragraph 5d) was revised.
## Immunization/Treatment Record

<table>
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<tr>
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<th>Date</th>
<th>Init.</th>
<th>Date</th>
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<td>Tetanus - Toxoid</td>
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## Communicable Diseases

(Enter Date Tested Positive/Treated and Initials)

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<td>Tuberculosis Active Treatment</td>
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<td>H.I.V.</td>
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<td>Other (Specify)</td>
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## Signature & Title

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## Instructions

- Immunization/Treatment to be administered, and form completed by a Licensed Nurse. See FSHOP 150-58, “Immunization and Preventive/Active Treatment of Certain Communicable Diseases” and FSHOP 155-2, “Human Sexuality.”
- Form to be brought forward with each admission.
- Form to be filed in Flow Sheet section of the ward chart.

---

**CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***

Florida State Hospital, Chattahoochee, FL 32324

Form 13, (Revised) Mar 01

Office of Primary Responsibility: Health Care Services Medical Service Director
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* Components of Human Sexuality Training (admission within 60 days and annually) in accordance with FSHOP 155-6 A, Human Sexuality. Initial and date when component complete. If education is offered and resident refuses, document in progress notes and re-offer education every thirty days. Date of completion, refusal, and or exclusion is input into the computer data base.
Family planning services are available to our pre-menopausal female residents who meet certain criteria and wish to take advantage of the opportunity for the counseling offered. If you qualify, we highly recommend your participation in the Family Planning Services Program. This clinic is provided by the Florida State Hospital Gynecology Clinic. Counseling and methods of birth control will be provided.

INFORMATION FOR DETERMINING NEED FOR FAMILY PLANNING SERVICES

1. What is your age? ................................................................................................................   _______________

2. Have you had a hysterectomy or tubal ligation? .................................................................   Yes ____   No ____

3. Are you currently on any type of birth control? ...................................................................   Yes ____   No ____
If yes, explain below.

The above has been explained to me and I understand. ..........................................................   Yes ____   No ____

COMMENTS/EXPLANATION: __________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Yes, I request Family Planning Services.  
______________________________  
Resident’s/Guardian’s Signature   Date

No, I decline Family Planning Services.  
______________________________  
Resident’s/Guardian’s Signature   Date
If no, please state reason for declining. 

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

INSTRUCTIONS: This form is to be completed on admission and as needed thereafter. Refer to Operating Procedure 150.43.

To be filed in the Service Implementation Plan section of the ward chart.
RESIDENT’S NAME AND NUMBER: _____________________________________________________

REVIEWS
On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

On a previous review you declined family planning services described on page 1. Do you wish to have these services provided at this time? Yes _____ No _____

Resident’s Signature ___________________________________________ Date ________________

Designated Staff Signature & Title ___________________________________________ Date ________________

*** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***

FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

Form 578, (Updated) Aug 97

FAMILY PLANNING SERVICES

Attachment 2

Questionnaire

Page 2 of 2

Operating Procedure 150-43
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<tbody>
<tr>
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<tr>
<td>Fam.</td>
<td>2. Heart Disease/Rheumatic Fever</td>
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<tr>
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<td>3. Diabetes</td>
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<td>4. Cancer</td>
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<td>6. Multiple Births</td>
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<td>7. Blood Disorders/Sickle Cell/Rh</td>
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<td>8. Lung/Tuberculosis/Asthma</td>
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<td>13. Gall Bladder/Liver</td>
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<td>14. Kidney/UTI</td>
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<td>20. Fertility Problems</td>
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<td>21. Hospital/Surgery/Accidents</td>
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<td>22. Blood Transfusion</td>
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<td>23. Other</td>
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**INSTRUCTIONS:** To be completed by the ward physician/ARNP in accordance with Operating Procedure 150-43, “Family Planning Services.”

To be filed in the Data Base section of the ward chart.
### Resident's Name & Number:

______________

### Allergies:
- Drug
- Food
- Other

### Medications:
- Current

### Immunizations:
- (Date) MMR
- TD
- Flu
- Pneu
- HBV
- PPD
- Result
- Other Imm.

### Tobacco:
- No
- Yes
- Type
- Amount
- Stopped (Date)

### Alcohol:
- No
- Yes
- Type
- Amount

### Street Drugs:
- No
- Yes
- Type
- Amount

### Tobacco/Alcohol/Drugs, Past Problems:
- Date of last use

### Therapy

### Nutrition:

### Recent Weight Change:
- No
- Yes
- Describe

### RPR or VDRL:
- Date
- Result

### U/A:
- Date
- Result

### GC Culture:
- Date
- Result

### Chlamydia Culture:
- Date
- Result

### ATTACH CBC AND SMA-15 TO THIS FORM.

### Sexual History:
- HBV/HIV Risk: Low
- Moderate
- High

### Contraceptive History:
- Method last used/now using
- Other methods used
- Problems with method

### Signature/Title: ____________________________ Date: ________________

### For Women Only

#### Menstrual History:
- Onset
- Yrs
- Regular: No
- Yes
- Amount
- Every ___ days for ___ days
- Problems
- LMP
- Normal?
- If no, LNMP

#### Pap Smear:
- Last Done
- Results

#### Mammogram:
- Date
- Results

#### Self Breast Exam:
- No
- Yes
- Frequency

### Obstetrical History:
- Gravida
- Para
- Full Term
- Preterm (<2500 gms)
- Abortions (<20 wks. Spont./Elective)
- Living Children
- Multiple Births

### Signature/Title: ____________________________ Date: ________________

---

**CONFIDENTIAL & PRIVILEGED INFORMATION**

**FOR PROFESSIONAL USE ONLY**

FLORIDA STATE HOSPITAL, CHATTahoochee, FL 32324

Form 586, (Updated) Aug 97

Office of Primary Responsibility: Clinical Director

Attachment 3
Page 2 of 2
Operating Procedure 150-43
RESIDENT’S NAME AND NUMBER: ____________________________________________

BENEFITS: I am voluntarily receiving oral contraceptives with estrogen and progesterone (birth control pills) as a method of family planning. I am aware that birth control pills are NOT guaranteed to be 100% effective, but can be over 99% effective if used correctly all the time. I have been told that in addition to their benefits as a method of birth control some women experience the following benefits from using birth control pills:

- Decreased menstrual cramps
- Decreased menstrual bleeding
- More regular menstrual bleeding
- Improvement in acne

RISKS: I am aware that while using birth control pills, I may have the following side effects: nausea, spotting between periods, depression, breast tenderness, weight gain or weight loss, headaches, darkening of the skin on my face, high blood pressure, worsening in acne, greater change of infections in the vagina, changes in sex drive.

In addition to the above pill side effects, I have been told that birth control pills may be associated with blood clots of the legs or lungs, strokes, heart attacks, gallbladder disease, liver tumors, and that these side effects may rarely result in death. The risk of heart attack may be increased if a woman is over 35 or smokes more than 15 cigarettes a day, or both.

I have been told that in order to lessen the chances of serious problems, it is my responsibility to go to a nurse or a doctor if I start having the following symptoms:

- SEVERE HEADACHES
- BREAST LUMP
- BLURRED VISION OR LOSS OF VISION
- SEVERE DEPRESSION
- CHEST PAIN
- YELLOWING OF SKIN AND EYES
- ABDOMINAL PAIN
- IF I SKIP A PERIOD

I UNDERSTAND THAT I SHOULD NOT TAKE BIRTH CONTROL PILLS IF I AM PREGNANT OR WHILE I AM BREAST-FEEDING A BABY.

STopping PILLS: I have been told that I have the right to stop using the pills at any time. I understand that a woman is most likely to get pregnant if she and her partner do not use any birth control method. I have been told that after stopping pills, I should use another means of birth control until I have had three (3) regular periods before I try to get pregnant.

ALTERNATIVES: The other means of contraception have been explained to me.

INSTRUCTIONS for the use of the pills have been given me.

QUESTIONS: I have been given the chance to ask questions about pills and about this consent form.

RESIDENT’S SIGNATURE: _____________________________________________ DATE: ___________________

WITNESS’ SIGNATURE: ___________________________________________ TITLE: __________________

INSTRUCTIONS: Form to be completed by Gynecology Clinic staff in accordance with Operating Procedure 150-43, “Family Planning Services—Oral Contraceptive Consent Form.”

To be filed in the Legal section of the ward chart.

*** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***
FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

ORAL CONTRACEPTIVE CONSENT FORM
Attachment 4
Page 1 of 2
Operating Procedure 150-43
INSTRUCTIONS FOR YOUR BIRTH CONTROL PILLS

1. Name of your pills ____________________________________________________________.

2. Start your pills the Sunday after your period starts. If it starts on Sunday, start that same night. Do this whether or not your period is still on.

3. Take one pill by mouth every day. For best results, pills must be taken at the same time every day. Start your pills at a time that will be convenient for you. We suggest at suppertime or bedtime to avoid nausea. Swallow one pill a day until you finish the whole pack.

4. After finishing all of your first pack of pills, start your second pack the next day. There should never be a day when you are not taking a pill.

5. Generally, your period will come sometime during the last seven (7) pills. If you fail to have your period, continue to take your pills as instructed, and tell the nurse. Remember, your period may be much different on pills than it was before you started taking birth control pills. You may only spot heavily--this does NOT mean that there is anything wrong.

6. If some bleeding or spotting should occur when you do not expect it, continue taking your pills as directed. If the spotting becomes heavier, tell the nurse. Do NOT quit taking your pills or you will NOT be protected from pregnancy.

7. If you forget a pill, take the forgotten one (yesterday's pill) as soon as you remember it. Take today's pill at the usual time. Pregnancy can occur if you miss one pill, but the chances of pregnancy increase with each pill missed. If you miss a pill, ask your partner to use a rubber (condom) until you finish all the pills in that package.

8. If you have any of the following problems, tell the nurse: BAD headaches, blurred vision, leg pains, abdominal pain, chest pains.

9. If for any reason you become seriously ill, have an operation, or go the hospital for tests, by all means, tell your doctor you are taking birth control pills. It is important for him to know.

10. You must have a complete physical examination once a year.
RESIDENT'S NAME AND NUMBER: _____________________________________________________

BENEFITS: I am voluntarily choosing to use an intrauterine device (IUD) as a method of family planning. I am aware that the IUD is NOT guaranteed to be 100% effective, but can be 97.99% effective if used correctly. It can be even more effective if foam and/or condoms are used at the mid-point between periods. The insertion of the IUD has been explained to me.

RISKS: I am aware that while using an IUD as a method of family planning, I may have the following side effects: long and heavier periods, cramping during or after insertion of the device, more cramping during my periods.

In addition to the above effects, I have been told that IUD's may be associated with more serious complications such as puncturing the uterus, abscesses and blood stream infections (sepsis). IUD's may also lead to ectopic pregnancy, sterility or death. Infection seems to be even worse if I am pregnant and I know that I should seek medical attention immediately if I think I am pregnant.

I have been told that in order to lessen the chances of serious complications from my IUD, it is my responsibility to report to the nurse or doctor if I start having the following symptoms:

- Pain or tenderness in my abdomen
- Unusual bleeding from the vagina
- Fever or chills
- Bad discharge from the vagina (heavier or bad odor)
- Missed menstrual period
- Cannot feel IUD string
- Can feel the plastic part
- See that the IUD has come out

ALTERNATIVES: The other means of birth control have been explained to me.

DECISION NOT TO CONTINUE USING AN IUD: I have been told that I may have my IUD removed if I want it removed. Only a qualified medical person should remove an IUD. I understand that a woman is most likely to get pregnant if she and her partner do not use any birth control method.

INSTRUCTIONS for using the IUD have been given to me. I understand how the IUD is inserted. I have been taught how to check for the strings of my IUD. I have been given written information about the IUD and I will read it.

QUESTIONS: I have been given the chance to ask questions about the IUD and about this consent form

RESIDENT'S SIGNATURE: ____________________________________________ DATE: __________________

WITNESS' SIGNATURE: ____________________________________________ TITLE: __________________

INSTRUCTIONS: Form to be completed by Gynecology Clinic staff in accordance with Operating Procedure 150-43, "Family Planning Services--Intrauterine Device Consent Form."

To be filed in the Legal section of the ward chart.

*** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***

FLORIDA STATE HOSPITAL, CHATTAHOOCHEE, FL 32324

Form 584, (Updated) Aug 97

Office of Primary Responsibility: Health Care Services Medical Service Director

INTRAUTERINE DEVICE (IUD)

Attachment 5

Page 1 of 2

Operating Procedure 150-43
INSTRUCTIONS FOR YOUR IUD

1. The name and size of your IUD ________________________________.

2. You may have some cramps or spotting of blood for the first three (3) months. Whatever medication or treatments you use to relieve menstrual cramps will probably take care of this problem. You can have relations as soon as the spotting and cramping stops.

3. The first few monthly periods may be heavier and last a little longer than usual.

4. Use a second method of birth control, such as foam and condoms, for the first two (2) months you have an IUD.

5. You should check for your strings once each week, especially after your monthly period, to make sure your IUD is in place. To check for your strings--insert your finger into your birth canal until you can feel the round opening of your womb. It should feel like the tip of your nose. If you can not feel the strings, or if you feel any part of the plastic you must use some other method of birth control until you can come to the clinic.

6. If you wear tampons do not do so until after the first period. It is possible for the IUD string to get caught on a tampon and be pulled out of place.

7. Your IUD may come out. This does not happen very often but if it does, remember you are not safe from pregnancy. Report to your nurse and use condoms and foam as a birth control method.

8. Remember: before flushing the toilet, or throwing away a sanitary napkin, look to see that the IUD has not come out.

9. If you should have any unusual problems such as--heavy unusual vaginal bleeding, fever, abdominal pains or tenderness, severe cramps--report to your nurse or doctor.

10. If a monthly period is missed, report to the nurse.

11. You must have a check-up four (4) to five (5) weeks after your IUD has been inserted and then once a year. These check-ups should be done at a time when you are not having your monthly period.